REPORT OF MEDICAL SERVICES REVIEW COMMITTEE*

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

We reproduce in full in the following pages the summary of recommendations of the Medical Services Review Committee published in its report "A Review of the Medical Services in Great Britain." *The Committee, which came to be known as the "Porritt Committee," was appointed in the autumn of 1958, under the chairmanship of Sir Arthur Porritt, P.R.C.S., by the following organizations: the Royal College of Physicians of London; the Royal College of Surgeons of England; the Royal College of Obstetricians and Gynaecologists; the Royal College of Physicians of Edinburgh; the Royal College of Surgeons of Edinburgh; the Royal Faculty of Physicians and Surgeons of Glasgow; the Society of Medical Officers of Health; the College of General Practitioners; and the British Medical Association. Its terms of reference were: "To review the provision of medical services to the public, and their organization, in the light of ten years' experience of the National Health Service, and to make recommendations." The members of the Committee (whose names are listed at the end of the summary) were not, the report states, "official representatives of the sponsoring bodies." They were "a group of doctors representing medicine in all its branches, yet having no particular allegiance to any medical organization or interest, who for the first time since 1948 have set about the task of making an objective review of the medical resources of the United Kingdom."* [See also leading article at p. 1171.]

PRELIMINARY CONSIDERATIONS IN DEVELOPMENT OF HEALTH SERVICE

1. We have examined the health service schemes in other countries. It is impossible to make any valid comparisons, but we have no evidence that patients receive better services under systems different from our own Health Service.

2. Changing social conditions, the spread of health education, and scientific advance have had their influence on the practice of medicine. Medicine is no longer solely a partnership between doctor and patient. Three parties are now concerned—patient, doctor, and the State.

3. The community must decide what proportion of its resources can be spent on the Health Service. The profession can only advise on what facilities are necessary. The first consideration of a doctor, whether in a State Service or not, must be for his patients.

4. There has been a lack of overall planning to keep development in line with social and medical changes. We stress that the practising doctor must have an adequate voice in the planning of the Service. The public should appreciate that there is no such thing as a free health service.

5. The success of the Service will, and must always, be judged by the personal attention given by the doctor to his patients. The individual doctor must be left free to ensure that the service is conducted on a personal basis.

6. We welcome the establishment of a Review Body on professional remuneration and we think that, wisely used, this could be a potent force in restoring the profession's confidence in the Government's administration of the National Health Service.

7. All the benefits promised of a National Health Service have not materialized, but having studied evidence from medical and lay organizations and public opinion as disclosed in the Gallup Poll, we early concluded that basically the concept of a National Health Service is sound.

THE ORGANIZATION OF THE NATIONAL HEALTH SERVICE

8. The Health Services of the country have been used for electioneering propaganda, and we deplore this.

9. We do not consider that any practical advantages would accrue either to the public or to the profession by placing the Health Service under the administration of an independent corporation.

10. We recommend the assimilation of as many of the Government medical services as practicable within one Government Department. The Minister of Health should always be of Cabinet rank.

[*Elliott & Fry*
Sir Arthur Porritt.

11. The present tripartite administration has isolated doctors in the three main branches of the Service. Examples are given of the adverse effects of this artificial division of the administration.

12. At present funds are allocated both from central and local government to different authorities responsible in the same area, for various parts of the Service. This method of financing the Service has led to isolated rather than co-ordinated policies, and to a loss of economy and efficiency.

Unified Administration

Area Health Boards

13. We recommend that the responsibility for the administration and co-ordination of all the medical and ancillary services in any area should be in the hands of one authority only—an Area Health Board.

14. We recommend that the boundaries of the Area Health Boards should be designed to meet the needs of community medical care in its widest sense, embracing all the services available in the area.

15. Pilot schemes should be introduced on an experimental basis in various parts of the country to ascertain the most appropriate size of the areas. Population should be one of the major factors.

16. The Area Health Board should be responsible both for the overall planning and development and the

**A Review of the Medical Services in Great Britain, Report of the Medical Services Review Committee,* 1962. Social Assay, London. 18s. net.

administration of all the services in its area. We recommend the creation of a number of subsidiary councils responsible to the Area Health Board for the day-to-day administration of individual services.

17. The Chief Officer to the Area Health Board should hold a medical qualification.

18. We do not recommend any change in the administration of teaching hospitals. In so far as they have an important responsibility in community care there should be the closest liaison between the governing body of the teaching hospital and the Area Health Board or Boards. This we recommend should be achieved by cross-representation.

19. We hold the view that the preventive and personal health services can only be effectively integrated with the family doctor and hospital services by transferring them (services and staff) to the Area Health Boards. These services should be co-ordinated through a newly created Department of Social Health, based on the principal hospital in the area and placed under the control of a consultant in social health, who might well be recruited from among existing medical officers of health.

20. Local authorities should be advised on matters of health and hygiene by consultants in social health seconded from the Area Health Board.

21. A comprehensive Department of Social Health should be established in each area general hospital. The Department would be responsible for the deployment of social workers and for epidemiology.

22. The personal health services, e.g., ambulance and transport service; vaccination and immunization; mental health functions (including the provision of hostels, training and industrial centres): and "Care and After-care" services, which provide for cases of tuberculosis and of venereal disease, health education, convalescence, and nursing equipment, should be transferred to the Area Health Board.

23. The welfare functions under the National Assistance Act, 1948, should remain with the local authority.

24. We see no reason to retain existing Hospital or Hospital Group Management Committees. Day-to-day administration should be undertaken by a House Committee advised by the Medical Committee of the Hospital.

25. The Area Health Board must enjoy a high degree of autonomy in administering and planning the services under its jurisdiction.

26. All the professions involved in the Service should be adequately represented on the Area Health Board.

Forward Planning and Operational Research

27. The co-ordination achieved by the creation of Area Health Boards will promote forward planning of the Medical Services both locally and nationally.

28. Full statistical information and the results of inquiry and research are essential if the National Health Service is to be successfully developed. There must be co-ordinated forward planning of the Health Service as a whole both in a particular area and nationally. Each Area Health Board should take special steps to promote operational research, and they should join together in creating Regional Planning Committees to deal with those services which can be planned economically only over a wider area. The data collected by Area Health Boards should be transmitted to the Regional Planning Committees and to the Health Departments.

29. The Service must have available to it the best professional advice at all levels, and we recommend the establishment of Statutory Professional Advisory Committees to Area Health Boards and at national level we recommend that the Central Health Services Council should be replaced by an Advisory Committee consisting of the chosen representatives of the professions. All these bodies should have available to them the same data as are supplied through the Area Health Boards to the Health Departments.

THE NATIONAL HEALTH SERVICE AND THE NATIONAL ECONOMY

30. Economical operation of any public service carries with it the danger that the Government may seek to lay down standards and impose a uniformity which is incompatible with professional freedom. We stress that the only safeguard is to ensure an alternative to which doctors and public alike can turn, by the encouragement of private practice.

31. We have considered whether a direct payment by the patient at the time he seeks advice would lead to a more enlightened use of the National Health Service. We think that the possible advantages of a direct payment should be the subject of continuing study.

PRIVATE MEDICAL PRACTICE

32. A patient should never be denied the right or opportunity of seeking private medical advice. We attach the greatest importance to the preservation of private medical practice which events of the past fourteen years have tended to discourage.

33. Private bed accommodation both in N.H.S. hospitals and outside the Service is grossly inadequate.

34. Private bed charges in hospital have reached an astronomical level without any improvement in the amenities offered. There has been no revision of the schedule of private fees since 1953.

35. There is evidence of a demand by the public for a more reasonably priced private bed.

36. A patient occupying a private bed has to meet heavy charges even though he is saving the hospital the cost of a public bed. We recommend as a matter of urgency a radical change in the method of calculating private bed charges and the introduction of a medium-priced private bed.

37. Private beds should be available to general practitioners.

38. We recommend the provision of drugs for private patients on precisely the same terms as those for National Health Service patients.

39. Until 1960 when it was abolished by the Royal Commission on Doctors' and Dentists' Remuneration, part-time consultants enjoyed a special weighting factor to compensate them for their continuing and overall responsibility for National Health Service patients. We recommend the restitution of the weighting factor as one way of ensuring the preservation of private practice.

40. The House of Lords decision on the tax assessment of part-time consultants will have an adverse effect upon private practice. We recommend the speedy introduction of amending legislation.

41. Provident and Insurance Schemes should be encouraged by the recognition of patients' contributions as allowable deductions in the assessment of tax.

PROFESSIONAL FREEDOM

42. We are satisfied that the doctor has retained his clinical freedom. We suggest that the very small number

of formal complaints by the public against doctors is one indication of the public's general satisfaction with the Service.

RESEARCH

43. We conclude from our study of existing arrangements for the co-ordination of research that basically they are now working well within the financial limits imposed. We recommend, however, that the Clinical Research Board should play a much greater part in stimulating and promoting research.

44. Doctors should not be discouraged, on financial grounds, from making research a whole-time career.

45. Area Health Boards should be encouraged to provide both the facilities and the contractual time for consultants to carry out more research.

46. There is a wide range of uninvestigated clinical material in general practice. Financial help is required to defray secretarial and other expenses, and to compensate for loss of remunerative employment. Steps should be taken (1) to develop designated "research practices" with extra staff, (2) to give more support by way of grants and fellowships, and from Exchequer funds, and (3) to appoint a general practitioner member to the Clinical Research Board.

47. There is scope for operational research in the field of Public Health. The benefits of integrating the three branches of the Health Service would be reflected equally well over the field of research.

GENERAL PRACTICE

48. We stress the importance of general practice. The title "General Practitioner" satisfactorily describes not only the broad scope and the full measure of service he is expected to give, but also the wide range of interests in clinical and social medicine which he must develop.

49. Advances in medicine and access to diagnostic aids now make it possible for a general practitioner to do more for his patients than he could in the past. Changes have occurred in the pattern of his work and the scope of general practice has increased.

50. We have found little substance in the allegation that general practitioners have suffered a loss of status. There have been changes in his work, but, despite the defects of the N.H.S. which should be remediable, we are satisfied that there is nothing to prevent an individual practitioner from reaching a high standing in his profession.

51. The family doctor service is working to capacity, but the present shortage of doctors makes it inevitable that the existing maximum size of lists must continue for some time to come. We suggest as a long-term aim that the maximum size of lists should be 2,500 patients for an urban doctor and 2,000 for a country doctor. Reduction must not be accompanied by a diminution of income, and although this might lead to an increase in the cost of the family doctor service we demonstrate that savings could be effected in other directions.

Remuneration and the Need for Incentives

52. There should be no undue discrepancy between the total career earnings of general practitioners and of consultants. Methods of remuneration in general practice have an important bearing on the standards of work.

53. The capitation system and the central pool are examined. We express the firm view that both the capitation method of payment and the pool system at present fall short of providing the best incentives and encouragement to good general practice.

54. We are not in favour of a salaried service, which would we think contravene the traditional freedom and independence of the general practitioner.

55. We have examined the merits and demerits of a system of payment by item of service. We believe that though such a scheme would have some advantages it would be difficult to administer and would require complicated and time-wasting machinery both for payment and to avoid abuse.

56. Although we think the capitation system is far from ideal we have received no evidence which persuaded us that other methods of payment would prove any more successful.

57. The National Health Service must be available to all, but its use must not be compulsory. On the evidence we have received we do not think that public opinion supports the view that the patient at the time of consultation should make a direct contribution to the doctor.

Freedom of Choice and Mobility

58. We are satisfied that the existing regulations governing the choice of doctor do not transgress the important principle of freedom of choice.

59. Registration of a patient with a doctor is essential. The regulations governing registration and change of doctor impose a slight but necessary limitation upon freedom of choice.

60. General practitioners have suffered a loss of mobility as a result of the abolition of the right to buy and sell the goodwill of practices. It has, however, eased entry into general practice for young men and women who no longer have to find large sums of money at the beginning of their careers. We found little support for the restoration of the right to buy and sell goodwill.

61. To assist mobility in general practice we recommend that Executive Councils should view more favourably applications from established practitioners for smaller practices in other areas.

Postgraduate Preparation and Education

62. We consider that any possible abuse of the trainee general practitioner scheme can adequately be safeguarded by selection committees when judging the suitability of prospective trainers. We recommend that the principle of trainee assistantships should be developed in other branches of the profession such as preventive medicine and occupational health. We recommend that a trainee while being attached to one practice for a year should be allowed to visit for short periods other types of practice.

63. All general practitioners should be encouraged to attend regular formal postgraduate training courses. Such courses should be planned over periods of at least five years. The value of less formal means of education must not be overlooked. The great need is to encourage every family doctor to make full use of the methods that suit him best.

Patterns of General Practice

64. It has been put to us that single-handed practice is likely to decline, but there must always be a place for the general practitioner who prefers to work on his own. We therefore recommend that interest-free loans for building and improving practice premises should be available to single-handed practitioners. Lock-up

surgeries though still inevitable in industrial areas should be discouraged.

65. Partnerships are a natural development to suit present-day conditions and the need for liaison between doctors in general practice.

66. Group practice has been an important major development in general practice and should be encouraged. Group practice loans have done more to help general practitioners than the provision of health centres. We recommend the attachment of health visitors, home nurses, and midwives to group practices.

67. Cover for off-duty time is ideally arranged through an assistant, a partner, a colleague, or a rota scheme. The right of a patient to see his own doctor whenever reasonable and possible must nevertheless be preserved.

68. We deprecate the abuse of systems of contracting out to impersonal commercial deputizing organizations. Nevertheless in certain large cities properly organized deputizing services may be a useful supplement to more traditional arrangements.

69. Health centres have so far proved to be costly, large, and complex. They have not proved popular with the profession and patients have found them impersonal. We recommend that further development in health centres should remain on an experimental basis.

Organization

70. Appointment systems in general practice should be introduced wherever practical, but adequate arrangements must be made for dealing with emergencies.

71. All general practitioners should have direct access to the pathological and diagnostic radiological departments of hospitals.

72. The General Practitioner Centre at Peckham is described. We express the hope that it will become the prototype of similar centres elsewhere. It is suggested that they could be sited in some of the 1,250 small hospitals which are destined to be superseded by district general hospitals.

73. These centres promote close co-operation between general practitioners and consultants, and those working in the field of preventive medicine.

74. We stress the importance of domiciliary consultations. The family doctor should always be present.

75. In domiciliary care the family doctor needs the help of skilled ancillary workers and medical auxiliaries. The general practitioner should be the clinical leader of the domiciliary team.

76. The health visitor is of invaluable help to the family doctor. It is important that the advice given to individuals or families by the health visitor and doctor should be consistent.

77. There is a need for recruitment and training of an increasing number of health and social workers.

General Practice and Hospital Care

78. There should be sufficient family doctors to enable them to undertake their general practice commitments and still enable them to take part in hospital work.

79. The general practitioner should be encouraged whenever appropriate to look after his own patients in hospital.

80. More general-practitioner hospital beds should be provided.

81. Consultants' time should not be taken up with the care of patients admitted to hospital with straightforward complaints in cases where the general practitioner could retain full clinical responsibility in a general-practitioner hospital.

82. In general-practitioner hospitals patients can receive continuing personal care from their family doctors. Patients appreciate the advantages of admission to a hospital near their home. Smaller hospitals should not be closed because of administrative convenience or temporary staffing shortage.

General Practitioners with Special Interests

83. General practitioners should be encouraged and trained to develop special interests—as for example in obstetrics, general medicine, paediatrics, geriatrics, and psychological medicine—particularly when they are working in partnerships and group practices.

Accident Cases

84. The family doctor has an important part to play in the initial treatment of accidents. He should have access to sterile dressings and the necessary instruments and equipment. In general-practitioner hospitals there should be a rota for the treatment of casualties and an efficient call system for emergencies.

MATERNITY SERVICES

85. The difficulties caused by the tripartite administration of the National Health Service are nowhere more apparent than in the operation of the Maternity Services. Active co-operation between the family doctor, hospital consultant, and health workers is essential.

86. There is an inadequate number of maternity beds in National Health Service Hospitals.

87. Obstetric departments should form part of the area general hospital. We are disturbed to find that in the Government's Hospital Plan for expanding and reorganizing the Hospital Service obstetric units in some areas are to remain separate from general hospitals.

88. There is a serious shortage of maternity beds in London and other large centres. Additional beds should be provided urgently. We recommend a material improvement in the Terms of Service of midwives and a greater use of married midwives on a part-time basis. The growing practice of discharging selected cases from hospital after 48 hours should be a temporary expedient and should not lead to loss of maternity benefit. Sufficient beds should be available to meet the needs of all maternity patients who choose institutional care, but while the present shortage of beds exists there must be careful screening of patients for confinement in hospital. In screening there must be close collaboration between consultant and general practitioner.

89. There should be an adequate number of neonatal units to cater both for the premature baby and the ailing infant. Pupil midwives as well as fully qualified midwives should be given training in these units.

90. There should be a more uniformly high standard of antenatal care and adequate clinical and laboratory resources should be made available. Greater emphasis should be given to the standards of antenatal care in both undergraduate and postgraduate training.

91. We support the view of the Cranbrook Committee that an increase in the number of maternity beds should be achieved by expanding the number available to general practitioners. Actual proportions must vary locally and in our view it would seem that a third to a half of maternity beds should be available for general practitioner use.

92. The booking of cases for admission to general-practitioner beds should be the responsibility of the

matron or admission officer, subject to agreed criteria decided locally.

93. General-practitioner maternity units while remaining separate entities should be sited as close to consultant-staffed hospitals as possible. Obstetricians and paediatricians should pay regular and frequent visits.

94. The precise relationship between consultant and general practitioner in regard to general-practitioner maternity units must be left to the individuals concerned.

95. Domiciliary midwifery remains an essential alternative to hospital confinement in normal cases. We are in general satisfied with the criteria for admission to the obstetric list. We attach the greatest value to a six months' resident obstetric post. More obstetric posts should be created for the benefit of would-be general-practitioner obstetricians.

96. The general practitioner who has not had the benefit of a resident hospital post in obstetrics should be encouraged to achieve obstetric skill by all other possible means, and the opportunity should be found for him to do this work in hospitals and in general-practitioner maternity units as a clinical assistant.

97. It is axiomatic that in domiciliary midwifery the general practitioner and midwife should work closely together. The general practitioner should always be present at some stage of the confinement.

98. We endorse the principle that the extra training and added responsibility of the general-practitioner obstetrician should be properly recognized in the fee he receives.

99. A general-practitioner obstetrician who recognizes an abnormality before the onset of labour should not be penalized by the loss of his fee for sending his patient to hospital. He should receive the complete fee.

100. The obstetric flying squad has proved of great value and should be expanded to provide a full national cover.

101. The pay and prospects of midwives need to be improved. Particular steps should be taken to encourage the return of those who have left the service.

102. Under a unified service midwives would have more opportunity of working both in hospitals and in the district.

103. Midwives and social workers should where possible be attached to a particular general practice.

104. The priority dental service for expectant mothers should continue.

105. Notwithstanding our general recommendations to secure effective co-ordination we recommend the establishment of local maternity liaison committees as envisaged by the Cranbrook Report.

106. We recommend the use of a standard co-operation card to be carried by the expectant mother and made available to all whom she consults.

SOCIAL AND PREVENTIVE SERVICES

107. The integration of the personal health services with other branches of the National Health Service has been particularly difficult because of the tripartite administration. *Ad hoc* liaison committees have been of some help, but do not go far enough.

108. We recommend that responsibility for the provision of the present local health authority personal health service, together with the Public Health medical and ancillary staff, should be transferred to the Area Health Board. One or more consultants in social health should be seconded to the local health authority to advise on environmental health.

Medical Care and the School Child

109. The School Health Service performs a special and valuable function and should be continued. We recommend, however, that it be transferred from the Ministry of Education to the Ministry of Health and administered locally by the Area Health Board through the Department of Social Health.

110. In some circumstances it is possible for family doctors to take part in the School Health Service if they so desire, but it is not always practicable or in the best interests of the child.

111. Effective exchange of information between the school doctor and the family doctor must be maintained.

112. The standard of specialist medical and surgical care for handicapped children in many schools leaves much to be desired and there is a need to improve and develop the provisions for education and health care of disabled children.

113. More attention should be given to the provision of day training centres for mentally subnormal children living at home.

114. The method of treatment of a mentally sick child should always be decided by a doctor. Child Guidance Clinics should be concerned solely with the educational needs of the child.

THE HOSPITAL AND CONSULTANT SERVICES

Hospital Planning

115. The expansion of the hospital service with properly planned modern hospitals is long overdue and we welcome the Government's White Paper " A Hospital Plan for England and Wales."

116. The basic unit in the hospital service of the future should be the area general hospital. As a general guide we recommend a ratio of 8 beds to 1,000 population distributed as follows:

3.4 acute beds
0.6 maternity beds
1.8 psychiatric beds
2.0 geriatric beds
0.2 other beds (including infectious diseases).

The area general hospital should provide the following services:

I. Patient Facilities

(*a*) Out-patient consultations and treatment.
(*b*) In-patient care and treatment.
(*c*) Diagnostic facilities for general practitioners.
(*d*) Casualty service.
(*e*) Advice and help with the social problems of patients through the almoner service and the department of social health.
(*f*) A laundry service for bedridden and incontinent patients.

II. Professional Facilities

(*a*) Undergraduate medical education and post-graduate instruction, as appropriate.
(*b*) Training of nursing and other ancillary staff.
(*c*) A centre and meeting place for the medical profession in the area.
(*d*) Facilities for research.
(*e*) The facilitation of operational research.
(*f*) A central sterilizing service. The need for sterile syringes for general-practitioner use may be lessened if disposable syringes prove to be satisfactory, but other sterilized articles, dressings, and equipment should be provided for general practitioners.

117. An area general hospital should include units for all the specialties normally covered in a general hospital. Beds should be available to general practitioners. There should be arrangements for dealing with accidents and casualties.

118. A dental unit and an isolation unit for emergency care of infectious diseases should be provided.

119. The Department of Social Health should be responsible for advice on cross-infection in both the area hospital and in the area it serves.

120. Certain specialties, e.g. neurology, plastic surgery, and thoracic surgery, should be planned on a regional basis by the Regional Planning Committee.

121. We commend the general principles to be followed in the building of a maternity unit, set out in the recent report of the Royal College of Obstetricians and Gynaecologists.

Mental Health

122. The organization of the mental health service should centre in the area hospital.

123. We are not in favour of special hospitals reserved solely for long-stay cases and we recommend that a psychiatric unit should be attached to the area hospital though we recognize the need for beds elsewhere for patients requiring continuing treatment. The treatment of mentally confused old people has now improved so much that the treatment of these patients in geriatric units should be encouraged.

124. Arrangements should be made for all mental patients on the admission list to be seen and assessed by a consultant psychiatrist.

Out-patient Departments

125. The system and design of an out-patient department should ensure a minimum distress to the patient and optimum working conditions for doctors and other staffs.

126. The association of out-patient facilities with ward units is discussed and the need for further experiment is suggested. We suggest the possible layout and organization of an out-patient department.

Casualty Departments

127. Each area general hospital should be responsible for the initial treatment of all accident cases occurring in its area. Special units should be attached to selected area general hospitals.

Special Services in the Area General Hospital

128. Certain special departments will need to be concentrated in certain selected hospitals.

129. We recommend that the bacteriological services administered by the hospital and Public Health Laboratory services respectively should be merged.

Private Beds

130. Each area general hospital should include an adequate number of private beds. These should take the form of a private block or a number of separate rooms or side wards attached to each unit.

Planning of an Area General Hospital

131. It is not practical or economical to design hospitals capable of ready adaptation to keep pace with advances in medical knowledge and techniques. It is better to allow for expansion at ground and other levels in the initial planning of the hospital.

132. In the planning of individual ward units we recommend that the following points should be observed:

(*a*) A room where doctors may interview relatives of patients;

(*b*) Another room should be provided for use by medical students when writing up case notes and in teaching hospitals for clinical teaching of students;

(*c*) A side room, including a laboratory, for research and treatment;

(*d*) There should be a visitors' room on each floor;

(*e*) There should be a day room for patients, with dining recess;

(*f*) There should be suitable accommodation in the hospital where relatives of dangerously ill patients can rest;

(*g*) Accommodation for parents should be provided close to the children's ward.

133. We recommend that nursing staff associated with special units outside an area general hospital (e.g. long-term psychiatric or geriatric) should be linked with the general hospital so that their duties are not confined to the special unit. Innovations in the pattern of in-patient care are likely, as for example team nursing. In hospital planning, building and overall administration should be such as to allow the greatest flexibility.

134. Small hospitals staffed by general practitioners with visiting consultants have helped to bring the two sections of the profession together to the advantage of doctors and patients alike. We would therefore regret the disappearance of these small hospitals solely in the interests of economy and indeed any other step which interfered with this valuable method of contact.

Medical Staffing

135. There is a serious shortage of junior medical staff and a promotion bottleneck below the grade of consultant at the senior registrar level. This shortage cannot be met from the ranks of newly qualified British doctors unless they are prepared to remain in the hospital service for a longer period than they are now doing.

136. We are doubtful whether the inducements proposed by the Joint Working Party on the Medical Staffing Structure in the Hospital Service are sufficient to encourage young doctors to remain in the hospital service for one or two years after full registration.

137. The post of medical assistant recommended by the Joint Working Party is contrary to the traditions of the teaching and voluntary hospital system which has always encouraged independent responsibility for the patient. We view the proposal with much anxiety.

138. All aspiring consultants should have had experience in non-teaching hospitals. We commend rotation schemes for senior registrars.

139. We recommend that young doctors should be given timely notice of promotion prospects in the various specialties, and the intake of trainees should be realistically related to future consultant vacancies.

140. Doubts are expressed as to whether general practitioners can make a substantial contribution towards hospital medical staffing. The pool method of payment acts as a financial deterrent.

141. If the financial disincentive of the pool method of payment can be overcome family doctors with special experience should be encouraged to play a useful part in the work of hospitals. We do not consider that a general practitioner should be away from his practice for more than one or two sessions a week.

142. We think there is little substance in the criticism that family doctors object to their colleagues holding appointments in specialist teams and seeing their patients on behalf of the consultant.

143. The general practitioner's association with a hospital provides an important aspect of postgraduate education.

144. A means should be found to facilitate the transfer of doctors from general practice to consultant work.

Hospital Administration

145. Senior hospital medical staff have an important part to play in the internal administration of hospitals.

146. Medical opinion in Great Britain is broadly opposed to the hierarchical system of medical staffing.

147. The influence of the hospital medical committee has declined because it has not been given the place and status it enjoyed before the N.H.S.

148. There has been some conflict between lay and medical administrators.

149. We support the view of the Bradbeer Committee that the internal administration of a hospital should be tripartite (i.e. medical, nursing, and lay), and we urge that all concerned should concentrate on making it harmonious and effective. We recommend that day-to-day medical administration should be carried out by the Honorary Secretary of the medical committee or one of the consultant staff chosen by his colleagues.

150. The aim of the Service should be to build up a pool of first-class administrators both medical and lay. Unless training facilities are provided it seems likely that there will be a shortage of administrators holding a medical qualification.

151. There is need for improved liaison between the medical staff and the lay administration. We express the view that there has, in fact, been an improvement in lay administration in recent years.

SPECIAL HOSPITAL SERVICES

Geriatrics

152. The first aim of a geriatric service should be to make it possible for the elderly to continue their lives in good health in their own homes.

153. Voluntary help is essential to the efficient care of the elderly, but it must be properly co-ordinated. A record of all elderly people in the area, particularly those living alone, should be introduced.

154. The facilities necessary for an effective geriatric service are described.

155. Advice should be available to elderly people before retirement, particularly to encourage them to take up some form of occupation either for gain or pleasure.

156. Seriously ill old people should be admitted to the acute medical or surgical wards. Those suffering from degenerative diseases should be admitted to special geriatric units attached to general hospitals.

157. We recommend new Psycho-Geriatric Units for the treatment of mentally confused patients.

158. We recommend temporary accommodation in hospital for elderly persons, to enable those caring for them at home to take a holiday.

159. There must be adequate provision in "homes" and hostels for old people who are frail and who do not need hospital treatment.

160. The admission of old people to the various types of accommodation should be under medical control.

161. Special care should be devoted to the proper housing of the elderly and medical advice should always be taken. Homes should be adapted to the special needs of old people.

162. All the social services should be fully deployed in the domiciliary care of the elderly.

The Young Chronic Sick

163. Special consideration should be given to the needs of the young chronic sick person, and where a long stay in hospital is indicated special facilities should be provided.

Mental Health

164. Owing to the changed conditions in psychiatric hospitals since the inception of the National Health Service we recommend:

(i) The Medical Superintendent as such should disappear.

(ii) His place should be taken by the Chairman of the Hospital's Medical Staff Committee, who should be a Senior Consultant of the Hospital, subject to annual re-election by the Committee.

(iii) The administration of the hospital should be a tripartite one, the Chairman of the Medical Staff Committee, the Matron/Chief Male Nurse, and the Secretary acting in close co-operation and being directly responsible for their areas of the hospital work.

(iv) If it is thought necessary to have an individual responsible to the House Committee for day-to-day matters of administration, that person should be the Hospital Secretary.

165. Undergraduate and postgraduate teaching and research in psychiatry should be expanded.

166. The general practitioner has an important part to play in the mental health service. More postgraduate education for general practitioners is an urgent requirement. Suitably experienced general practitioners should be encouraged to participate in the work of psychiatric out-patient clinics.

167. We recommend that consultants in paediatrics and neurology should be appointed on a sessional basis to the staff of hospitals for the mentally subnormal. There should be a more comprehensive assessment service with consultant supervision.

168. Child psychiatric services should be developed within the National Health Service which should be complementary in their functions to the Child Guidance Clinics of the local authorities. Priority should be given to the training of child psychiatrists.

169. The prison psychiatric services should be provided by the National Health Service, which should also provide psychiatric services for other penal institutions. Institutions should be developed for criminal psychopaths.

170. We consider that the training of the majority of psychiatrists in psychotherapy is still unsatisfactory. Further research into the various techniques employed is imperative.

171. More courses for the training of social workers, particularly health visitors, should be instituted as soon as possible. The health visitor must work in close co-operation with the general practitioner.

Chest Diseases

172. There is a need for closer integration of the chest services with other branches of medicine in the hospital service.

173. Reference is made to the problem of redundancy of staff in chest medicine. We recommend that a proportion of the staff whose prime function is to deal with patients suffering from tuberculosis should be absorbed into general medicine. The link between the public health and clinical aspect of tuberculosis control needs strengthening.

174. Chest units should be absorbed into general hospitals and a number of sanatoria should be preserved.

175. Heart surgery requires highly trained consultants and expensive and complex apparatus. It should therefore be planned on a regional basis.

176. We recommend the appointment of specially trained cardiologists to selected general hospitals.

Infectious Diseases

177. It should not be assumed that infectious diseases have been brought under control. The separation of infectious diseases from the general hospital is not desirable and in the planning of new hospitals special units for the treatment of these diseases should be included. Extra accommodation will be necessary in large towns to deal with occasional epidemics.

Venereal Diseases

178. All venereal diseases clinics should be part of the area hospital out-patient services. There is a residual need for special clinics to cater for married women, young people, and those who cannot attend without arousing suspicion.

179. The specialty must be covered by an adequate number of consultants. The present shortage can be overcome by improving the facilities for teaching. The venereologist in charge of undergraduate and post-graduate teaching should always be of consultant status.

180. Adequate in-patient accommodation for both sexes should be available with facilities for isolating patients in gynaecological wards.

Rheumatology: Physical Medicine and Rehabilitation

181. The physical medicine service is still far from complete and about 70% of all the consultants are centred in and around London. There is an urgent need to promote a rheumatology service in every region.

182. We indicate reasons for changing the present direction of physical medicine towards a therapeutic service with the emphasis on rehabilitation which we think the physical medicine consultant is particularly fitted to undertake.

183. The advantages of co-ordinating treatment during rehabilitation are discussed. We recommend the creation of well-equipped units in charge of a consultant in rehabilitation, who would need to have the highest academic qualifications and a sense of vocation. We recommend special residential units for the rehabilitation of sufferers from certain chronic disabling diseases.

Ophthalmology

184. The hospital eye service is working to full capacity and there is an urgent need to expand both staff and facilities. A hospital Eye Department should have not less than 25 beds. Units below this level should be dispensed with.

185. Suitably qualified general practitioners should be encouraged to work in hospital Eye Departments. The appointment of ophthalmic physicians should be encouraged.

186. There is a need to promote research in ophthalmology.

187. We recommend that the Supplementary Ophthalmic Service should continue alongside the hospital eye service for the foreseeable future.

188. Consultant ophthalmologists and ophthalmic medical practitioners should be entitled to prescribe spectacles for their private patients on the same terms as National Health Service patients.

189. We recommend that form O.S.C.1 should be required for every examination under the Supplementary Ophthalmic Service.

190. We recommend that the charge for National Health Service spectacles should be abolished in the case of people over 55 years of age.

Casualties and Accidents

191. We consider that minor casualties are diagnosed and treated less competently than major injuries.

192. Too many hospitals are receiving seriously injured people, and staffing shortages are such that immediate diagnosis and treatment is frequently carried out by junior personnel.

193. There is a need for an adequate number of accident units attached to selected general hospitals.

194. In the future we recommend that treatment in a comprehensive casualty and accident service should provide for minor, major, and complex cases. Details are given as to the way in which these groups of cases should be handled.

OCCUPATIONAL MEDICINE

195. We consider that a good standard of medical care is now provided by well-organized medical services in certain large private companies and in nationalized industries. The majority of small concerns are without any form of occupational health service.

196. The importance of industrial medicine is not sufficiently appreciated either by industry or by the medical profession. The facilities in the medical schools for education in industrial medicine need to be expanded and improved.

197. The future development of the occupational health service is discussed. We recommend the growth of private occupational health schemes run in association with and partly administered by the National Health Service.

198. We recommend that priorities in the provision of the service in the public sector should be decided by Area Health Boards under a general policy laid down by the Ministry.

199. We recommend that the Factory Medical Inspectorate and the appointed factory doctor should be transferred to the Ministry of Health.

200. More specialists and general practitioners are needed to ensure a steady expansion of the service.

201. It is important that the occupational health service should avoid becoming an extension into the factory of the general practitioner service.

202. We recommend the following safeguards to ensure the proper development of the occupational health services:

(i) All appointments for industrial medical officers should be advertised.

(ii) Selection boards should include a consultant in occupational health.

(iii) No medical officer should be dismissed without the concurrence of the Minister of Health, either side to have the right of appeal to the Minister.

203. Minimum salary rates laid down by the Ministry of Health, subject to negotiation with the British Medical Association, should be adequate in comparison with those paid in other branches of medicine. Minimum rates should be laid down also for general practitioners who undertake part-time duties. In the case of the public sector of the service, salaries should be paid by the Area Health Boards.

MEDICAL EDUCATION

204. The standard of medical care depends upon efficiency of medical education.

205. Recent changes in medicine demand a new outlook on medical education. There should be greater emphasis on social, community, and environmental medicine.

206. Undergraduate training must be thorough and basic. Graduation has ceased to be synonymous with full qualification.

207. Medical schools and hospitals have separate governing bodies and it is almost impossible for a clear policy to emerge. This is particularly true of the terms and conditions of service under which persons are employed. We recommend that the University Grants Committee should recognize the special requirements of medical training by allocating specific funds to the medical faculties.

208. There are shortcomings in research facilities, accommodation, and available teachers in the medical faculties of our Universities and it is becoming more and more difficult to give medical students all they need to prepare them for the practice of medicine. The present policy of curtailing expansion of our medical schools may have serious repercussions.

209. We stress the value of pre-registered hospital appointments but give instances of ways in which the system has broken down.

210. Insufficient time is devoted to the postgraduate training of junior hospital staffs, in particular to graduates from overseas.

211. The Royal Colleges and the universities have an important part to play in postgraduate preparation, but the Government has an equally important part as virtually the monopoly employer of doctors. We recommend that the Royal Colleges and universities and the Ministry of Health should combine to organize postgraduate training throughout the country.

212. Regional hospitals play a considerable part in postgraduate training and they must be given the help necessary to make their present efforts more effective.

213. We recommend a central independent professional body to co-ordinate postgraduate training, to provide accurate data on problems of manpower, and to devise and introduce new methods of training.

214. Special attention should be paid to postgraduate preparation and the continuing education of general practitioners.

215. We advocate the establishment in a few universities of well-supported departments for an impartial study of medical care without reference to medical politics and economic pressures.

RECRUITMENT

216. There are indications of a growing shortage of doctors, and in all sections of the Health Service an excessive burden of work hampers doctors in their efforts to practise efficiently.

217. The United Kingdom has always made an important contribution to the medical services of countries in other parts of the Commonwealth. Under the National Health Service doctors in Great Britain feel less free than formerly to travel overseas because of the difficulty of re-entering the National Health Service. It is urgently necessary for the profession and the Government to make it easier for British doctors to undertake periods of service overseas.

218. It is difficult to see how an adequate increase in the number of medical students can be accommodated without a lowering of teaching standards unless there are more medical schools and teachers.

219. We recommend that steps be taken immediately to establish a proper mechanism for recording all the facts relating to medical manpower, and that an attempt be made to arrive at an estimate of medical needs over the next twenty-five years.

220. We consider that the number of medical students should be increased over and above the restoration of the 10% cut made on the recommendation of the Willink Committee and that more funds be given to medical faculties to permit this. The competing attractions of other less demanding professions and the changing public attitude to medicine have had an adverse effect on recruitment. Teachers and schoolchildren have been hampered by a confused idea of medical practice.

221. The variety of educational requirements for entry into the various medical schools acts as a deterrent to medical recruitment. We express the hope that the new grant regulations will lead to a general clarification of the situation.

Professions Supplementary to Medicine

222. The contribution by ancillary workers in the provision of medical care is an extremely important one and there is a growing field for the use of their services. We are not satisfied that present legislation provides adequate supervision of the standards of training and examination.

223. There is a grave shortage of ancillary workers, particularly in the hospital service. In our view these deficiencies are in some measure due to unattractive scales of pay.

MEMBERSHIP OF THE MEDICAL SERVICES REVIEW COMMITTEE

Sir Arthur Porritt, P.R.C.S. (Chairman); Dr. G. F. Abercrombie; Professor T. Anderson; Dr. W. Ferguson Anderson; Dr. J. T. Baldwin; Professor I. R. C. Batchelor; Mr. A. C. H. Bell, P.R.C.O.G.; Sir Harold Boldero (died December, 1960); Mr. W. S. Braidwood; Mr. R. Brearley; Professor J. Bruce, P.R.C.S.Ed.; Dr. J. D. S. Cameron, P.R.C.P.Ed.; Dr. H. D. Chalke; Sir Andrew Claye (resigned July, 1961); Mr. E. Cope; Dr. A. B. Davies; Dr. T. B. S. Dick; Miss A. M. Dickins; Dr. J. R. Ellis; Dr. J. Fry; Dr. A. Rae Gilchrist; Dr. I. D. Grant (died April, 1962); Dr. C. F. Hawkins; Mr. W. Hawksworth; Mr. R. G. Henderson (died June, 1962); Brigadier H. L. Glyn Hughes; Dr. J. H. Hunt; Mr. A. Jacobs; Dr. A. M. Maiden; Mr. D. F. Ellison Nash; Professor I. Rannie; Professor T. Ferguson Rodger; Dr. J. M. Rogan; Mr. J. A. Ross; Sir James Paterson Ross (resigned February, 1962); Mr. T. Holmes Sellors; Dr. G. Swift; Sir Tudor Thomas; Dr. J. B. Tilley (resigned November, 1960); Dr. F. G. Tomlins; Dr. G. W. Townsend (resigned January, 1962); Dr. S. Wand; Professor R. C. Wofinden; and Dr. J. Wright, P.R.F.P.S.G.

Dr. D. P. Stevenson, Secretary.